New Jersey Department of Health and Senior Services
Office of Program Compliance–Reporting
P O Box 367
Trenton, NJ 08625-0367

FACILITY REPORTING INCIDENT DATA AND ANALYSIS YIELD (FRIDAY) GUIDELINES

Revised 2/2006

TO: All Assisted Living and/or Long Term Care Facility Administrators

An accused certified nurse aide (CNA), personal care assistant (PCA), or medication aide (CMA) is entitled to a hearing regarding the above-referenced allegation of abuse, neglect or misappropriation of resident property. In order to afford timely due process to the individual so accused, yet protect the vulnerable, frail and/or elderly residents of licensed facilities, the Department of Health and Senior Services (DHSS) requests that you provide all of the information required by the Facility Reporting Incident Data and Analysis Yield (FRIDAY) form within 15 business days of the incident date. This Department requires that the entire form be completed together with all information and supporting documentation requested therein.

Sections 1 through 14 shall be completed and the required supporting information submitted **even if the facility or government agency or other investigation process did not substantiate the allegation.** Further, **all information and supporting documentation** shall be submitted in response to this letter regardless of whether it has already been supplied to another government agency or official. Please remember that certificates and/or wallet cards are not permitted to be photocopied for any reason.

If more than one aide has been accused of this incident, a report for each accused aide shall be completed, and all of the requested information shall be attached to each form. For example, if 3 aides have been identified, please duplicate all information so that 3 separate packages are completed and submitted. You may place the 3 separate packages into one envelope for mailing/courier services.

Return the completed original form and legible copies of all supporting documents, and keep a copy of this form for your records. Packages shall be forwarded as follows:

Mailing Address via United States Postal Service:
Office of Program Compliance-Reporting
P. O. Box 367
Trenton, NJ 08625-0367

Overnight Couriers (DHL, FedEx, UPS):
Office of Program Compliance-Reporting
120 South Stockton Street, Lower Level
Trenton, NJ 08611-1730

Due to the volume of ongoing cases, it is difficult to notify you of the status of a particular case. Once all information has been received and reviewed, you will be notified of the determination in writing.

Thank you for your anticipated cooperation with this important matter. This program cannot succeed in its mission to protect the frail and/or elderly population of our licensed health care facilities without your complete participation.

Please be aware that the Nursing Home Administrators Licensing Board is notified of all instances where an administrator fails to respond to this request. Any sanctions that may be imposed against administrators are in accordance with N.J.A.C. 8:34-1 et seq., specifically N.J.A.C. 8:34-9.1(a)9, and N.J.S.A. 26:2H-27 and 26:2H-28.

If you are unable to meet the time frame required in this letter or have questions about the contents of this letter, please contact Regina Reali, via email (regina.reali@doh.state.nj.us) or telephone (609-984-8128).

Finally, remember to check the New Jersey Nurse Aide Registry prior to hiring any new nurse aides and again, periodically to check the status of all currently employed aides by visiting www.promissor.com then click on "Registry Services." N.J.A.C. 8:39-42.15(a) states, "No licensed long term care facility shall employ a person as a nurse aide without making inquiry to the New Jersey Nurse Aide Registry, by calling 1-800-274-8970, and to any other state where the facility believes the nurse aide to be registered." This also includes those individuals sent to the facility by private employment agencies. Certificates, wallet cards, and/or telephone verification sheets are not competent evidence of certification. Please note that Promissor's former toll-free number referenced in the above-quoted regulation is no longer in service.

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FACILITY REPORTING INCIDENT DATA AND ANALYSIS YIELD (FRIDAY)

PRINT OR TYPE YOUR RESPONSES

Information Requested about the *Accused Aide*:

Type of Allegation: Check all that apply

Abuse: ☐ Emotional ☐ Involuntary Seclusion ☐ Physical ☐ Sexual ☐ Verbal

☐ Neglect

☐ Misappropriation of Resident Property

Medication Aide ONLY: ☐ Incompetence/Negligence

Even if the accused was working in your facility through an employment agency, regardless of whether the individual is salaried by your facility or the agency, **you MUST answer Questions 1 through 8.**

1. Name of the Accused Aide: _____
2. Home Street Address: _____
   Apartment/Floor Number: _____
   P. O. Box Number: _____ (If not applicable, leave blank.)
   City: _____ State: _____ Zip Code: _____
3. Social Security Number: _____
4. Date of Hire: _____

Make sure that you take all possible steps to verify the accuracy of social security numbers as we have had incidents of individuals who use one number with their employer and another number with the DHSS and/or Promissor.

5. Complete only if the accused is not certified:
   a. Name of New Jersey Training Program attended:

      _____

      OR

   b. Reciprocity pending from the State of: _____ (CNAs only)

      AND

   c. Promissor ID Number: _____

      (The ID Number is listed on the passing exam score report and begins with NJ-06. Note: Regarding individuals who are not yet certified, keep a copy of the passing score report in the employee's file.)
6. Complete only if the accused is certified:
   See *Guidelines* prior to completing this section.
   a. Certificate Number: _____ (include the preceding letters in the certification number)
      Expiration Date: _____
   b. Verify the aide's current status and attach one copy of the current **(within the last 30 days)** certification verification sheet. This information may be obtained from the Department's registry vendor, Promissor, by visiting their website at www.promissor.com. Click on "Registry Services," then "NJ Personal Care Assistants/Nurse Aides" or "NJ Assisted Living Administrator/Medication Aide." Certificates and/or wallet cards are not permitted to be photocopied and submitted or retained as competent evidence of certification.
   c. Reciprocity from the State of: _____ (CNAs only)
      Expiration Date:

7. Identify any disciplinary action that was taken against the accused as a result of the investigation:

☐ Inservice Training ☐ Reassigned ☐ Suspended ☐ Terminated

☐ Other: _____

a. If terminated/suspended, was the accused rehired/reinstated? ☐ Yes ☐ No

b. Were the police notified? ☐ Yes ☐ No ☐ N/A

(If you checked "No" or "N/A" to Question 7b, you may leave the remainder of Question 7b blank.)

Name of Police Department: _____

Name of the Investigating Officer/Detective: _____

Telephone Number of the Officer/Detective: _____

Did the police conduct an investigation? ☐ Yes ☐ No

☐ A copy of the police report is enclosed. -OR- ☐ A copy of the police report is not enclosed.

Send a copy of the police report immediately upon your receipt of the report.

c. Submit copies of past and present disciplinary actions regarding resident care or any similar practice issues:

☐ Enclosed ☐ No prior disciplinary actions

8. At the time of the incident, the accused was: ☐ a facility employee ☐ an agency employee.

(If you checked "facility employee," you may leave Questions 8a through 8f blank.)

a. Agency Name: _____

b. Agency Contact Person: _____

c. Agency Mailing Address: _____

d. Agency City, State and Zip Code: _____

e. Agency Telephone Number: _____

f. Agency Email Address: _____

9. Collateral Due Process Hearings (facility, union, or governmental hearing):

a. Was a hearing offered to the accused to contest the allegations? ☐ Yes ☐ No

b. If yes, what is the date of the hearing? _____

c. ☐ A copy of the written decision by the arbitrator/hearing officer is enclosed. -OR-

d. ☐ A copy of the written decision is not enclosed, as there is no decision as of today.

Send a copy of the written decision immediately upon your receipt of it.

10. Provide proof [e.g., copy of time card(s), assignment sheet(s)] that on the date/time of the incident, the accused was on duty, assigned to the area or to the resident victim where the incident occurred.

- On duty; and
- Assigned to the area; OR
- Assigned to the resident/victim or otherwise had occasion to assist or care for the resident victim (if the resident victim's name is not listed on the assignment sheet, provide some other proof that the accused was taking care of the resident victim on the date and time of the incident; AND
- Highlight the Name(s) of the Accused Aide(s) and Resident Victim(s).

FACILITY REPORTING INCIDENT DATA AND ANALYSIS YIELD (FRIDAY)
(Continued)

11. Facility Information:
    a. Name: _____
    b. Mailing Address: _____
    c. City and **Zip Code** _____
    d. Administrator Name: _____
    Telephone Number: **( )** _____ Fax Number: **( )** _____
    Email Address: _____
    e. Director of Nursing Name: _____
    Telephone Number: **( )** _____ Fax Number: **( )** _____
    Email Address: _____
    f. Facility Investigator Name: _____
    Telephone Number: **( )** _____ Fax Number: **( )** _____
    Email Address: _____

12. Information Requested About the Resident Victim(s):
    a. Name(s): _____
    b. Age(s) at Time of Incident: _____ (no birthdates, please!)
    c. Actual date and time the incident occurred:
    d. At the time of the incident, was the victim alert and oriented? ☐ Yes ☐ No
    e. Is the victim <u>now</u> alert and oriented? ☐ Yes ☐ No
    f. Does the victim have dementia/Alzheimer's? ☐ Yes ☐ No
    g. Is the victim still a resident at the facility? ☐ Yes ☐ No ☐ Deceased
    If "No," please provide the resident's current address and telephone number:

    _____

    _____

    h. If this incident required a resident assessment, please include it with your investigation report. Note: Injuries may not immediately appear and will require additional assessments.

NOTE: If the accused abandoned his/her workstation without notifying anyone, identify all affected residents under his /her care. Please use the back of this page.

13. Office of the Ombudsman for the Institutionalized Elderly (OOIE) (if the resident victim(s) is (are) age 60 or older):
    a. Was this incident reported to OOIE? ☐ Yes ☐ No
    Name of Person to Whom Reported: _____
    b. Did the investigator substantiate the allegation? ☐ Yes ☐ No
    Case Number: _____
    Name of Investigator: _____
    OR
    ☐ A visit to the facility has <u>not</u> been made.

14. Investigation Report Requirements

a. Did the facility investigation substantiate the allegation that abuse, neglect, or misappropriation of resident property occurred? ☐ Yes ☐ No

b. Do the witnesses speak English? ☐ Yes ☐ No

If "No," identify the individuals and indicate language spoken:

_____

_____

c. The Facility Investigation Report - Details of the facility investigation report shall include:

- An explanation of what happened.
- How the accused was identified. A statement such as "the aide in question is..." is not acceptable. You must tell what you, the investigator, did, or the resident victim did, to identify the accused.
- Resident Assessment in relation to this incident. Remember, injuries may not appear right away and follow up assessment may be necessary.) Photographs are helpful but are not required.
- How you determined that this allegation was or was not substantiated.
- Finding(s), recommendation(s), and conclusion(s).
- Written statement as noted below.
- The signature of the facility investigator and date completed.
- If theft of checks was involved, a copy of the cancelled check(s) - front and back.
- If using the resident's telephone, a copy of the resident's telephone bill.
- If theft of resident's credit card was involved, a copy of the resident's credit card bill.

- **NOTE: Character references, summaries and the Reportable Event Record/Report forms are not acceptable.**

  Written Statements by the resident victim(s), accused, and witnesses
  A witness is...
  ...someone who saw and/or heard the incident while it was occurring;
  ...an employee and/or a visitor (e.g.,, a family member);
  ...someone to whom the resident victim spoke directly about the incident.

- Each written statement shall be on a separate sheet of paper. A sample individual statement form is enclosed for your use or reference.
- Every written statement shall be in the first person, the writer's own words, explaining in detail exactly what happened. Include the writer's printed name, daytime telephone number, date of statement, and signature.
- If a writer is non-English speaking, the written statement shall be in his or her own language. A written, signed, dated verbatim translation shall be provided.
- If a writer has difficulty writing or otherwise making a written statement, write or type the statement verbatim and have the individual sign and date the statement. Please make a notation on the statement signify9ing that you are providing a verbatim statement, print your name, sign your name, and date.
- If an individual making a statement cannot sign his/her name, the statement may be signed with an "X," if signed below the "X" by two witnesses.
- If the handwriting on any statement is not legible, please include a typed transcription that includes the writer's and the transcriber's signatures.

FACILITY REPORTING INCIDENT DATA AND ANALYSIS YIELD (FRIDAY)
(Continued)

INDIVIDUAL STATEMENT FORM

Complete the following 4 steps.
Attach additional sheet(s) if necessary. Sign and date additional sheet(s).

1. Where and when (date and time) did the incident occur:

2. Tell us step by step, in your own words, what happened (what you actually saw and/or heard).

3. Individual Completing Form:

   Name (Print): _____

   Daytime Telephone Number: **( )** _____

4. Signature: _____

   Date Completed: _____